

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 8 5 3 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

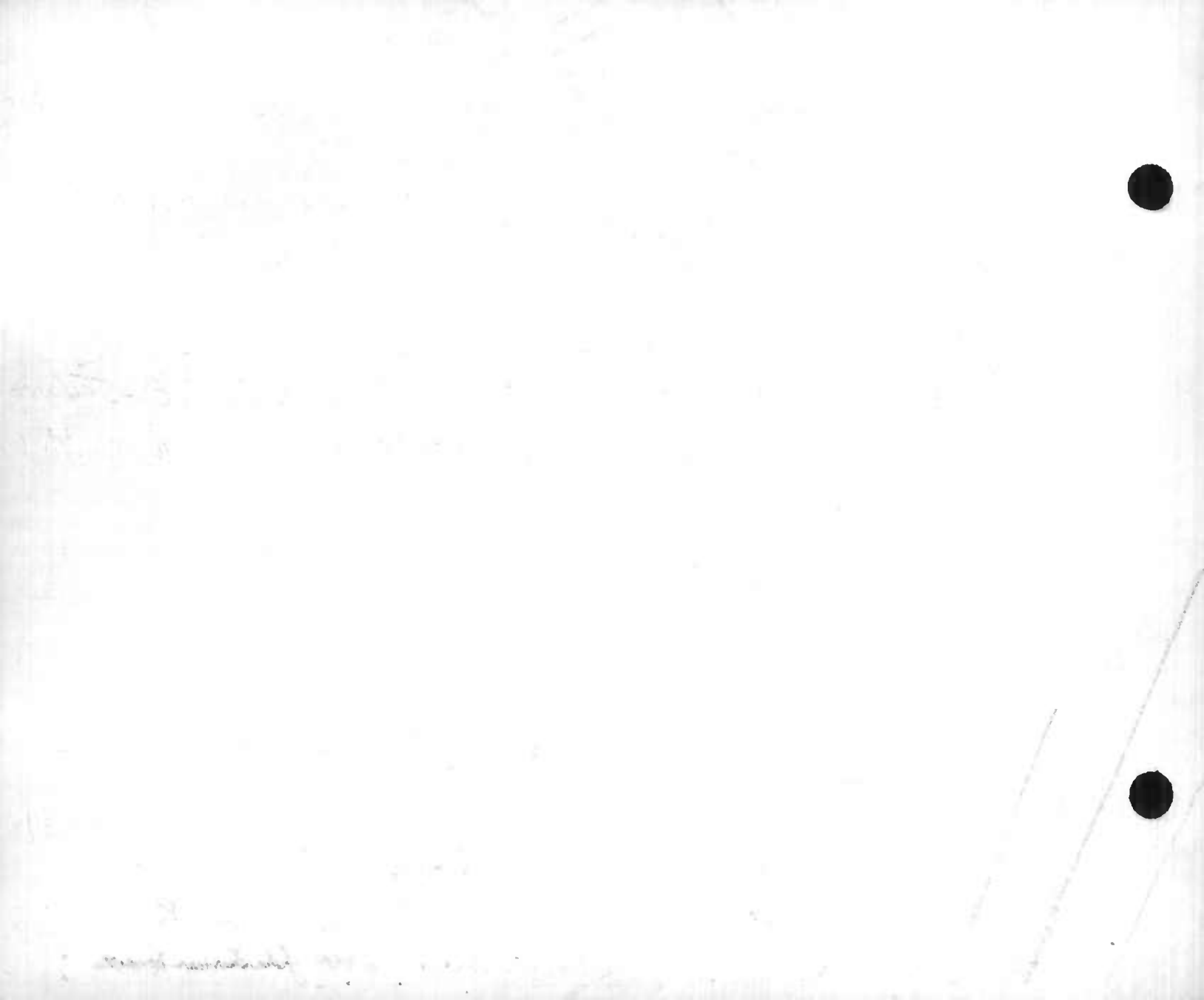
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT BANKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-22-84</b>		2b. HOUR <b>2:10 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>QUEEN ANNE'S MD.</b>	
10. CITY OR TOWN OF DEATH <b>POND TOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>RANGE NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABOR</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>KENT</b>	13c. CITY OR TOWN <b>ROCK HALL</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>R. RD 21661</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE BANKS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LIZA CUK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-</b>		17. INFORMANT NAME ADDRESS <b>MRS. DORISE HAYNSON 602 HIGH STREET CHESTERLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ca. lung carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-18</b> 19 <b>84</b> to <b>10-4</b> 19 <b>84</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10-4</b> 19 <b>84</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated <input type="checkbox"/> (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <b>Wayne D. Benjamin</b>		DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>10/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WAYNE D. BENJAMIN</b>		22e. ADDRESS <b>CHESTERTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>10-27-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>AARON CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rock Hall Kent MD</b>	
24. FUNERAL DIRECTOR <b>Emmett W. O'Connell</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 02 1984</b>			
		25b. REGISTRAR'S SIGNATURE <b>John S. [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH M. CARNEAL</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>Oct 20, '84</b>		7b. HOUR <b>8:39 AM</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 4, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		9. UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YES</b>		8. UNDER 24 HRS. HOURS MIN. <b>YES</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Annes County MD</b>					
10. CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Actuary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			
13a. STATE <b>MD</b>			13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13d. STREET ADDRESS <b>5220 York Road 21212</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Carroll</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(Unknown)</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220 24 3275</b>			17. INFORMANT ADDRESS <b>Edgar F. Carneal, Centreville, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lymphocytic lymphoma</b> DUE TO OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>approx one year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____											
18a. DATE OF OPERATION			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>84</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Queenstown, Md. 21658</b>					
22a. I certify that (I) (the hospital) attended the deceased from <b>Oct 2 1984</b> to <b>Oct 20 1984</b> , that (I) (we) last saw the deceased alive on <b>Oct 16 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Willard F. Smith MD</b>			22c. DEGREE <b>MD</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>10/20/84</b>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Willard F. Smith MD</b>			22g. ADDRESS <b>Queenstown, Md. 21658</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/23/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>				
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., MD 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NEW YORK: J. J. LINDEN & CO., INC.  
100 WALL STREET, NEW YORK 5, N.Y.

UNITED STATES DEPARTMENT OF COMMERCE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 3 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
TRIA MARIE CASTIGLIA								10-14-84				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
female	white	7/6/63		21 YRS.						10-14-84		6:40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Hollywood, Calif		U.S.A.				Queen Anne's County						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Stevensville		Bay Bridge		student									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		a.A. Co.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		917 Blue Ridge Dr.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Noel Francis Castiglia		Linda Lou Wagner											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
no		219-82-0316		Noel Castiglia Ann. Md. 21401									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-14-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				pedestrian struck by a vehicle									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
		bridge		Bay Bridge Queen Anne's Co., Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Margarita A. Korell, M.D.		Assistant		10-14-84									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		10/20/84		Assumption Cemetery		Green Farm Conn.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Hardesty Funeral Home		12 Ridgely Ave Ann. Md. 21401		OCT 18 1984		John Davidson							



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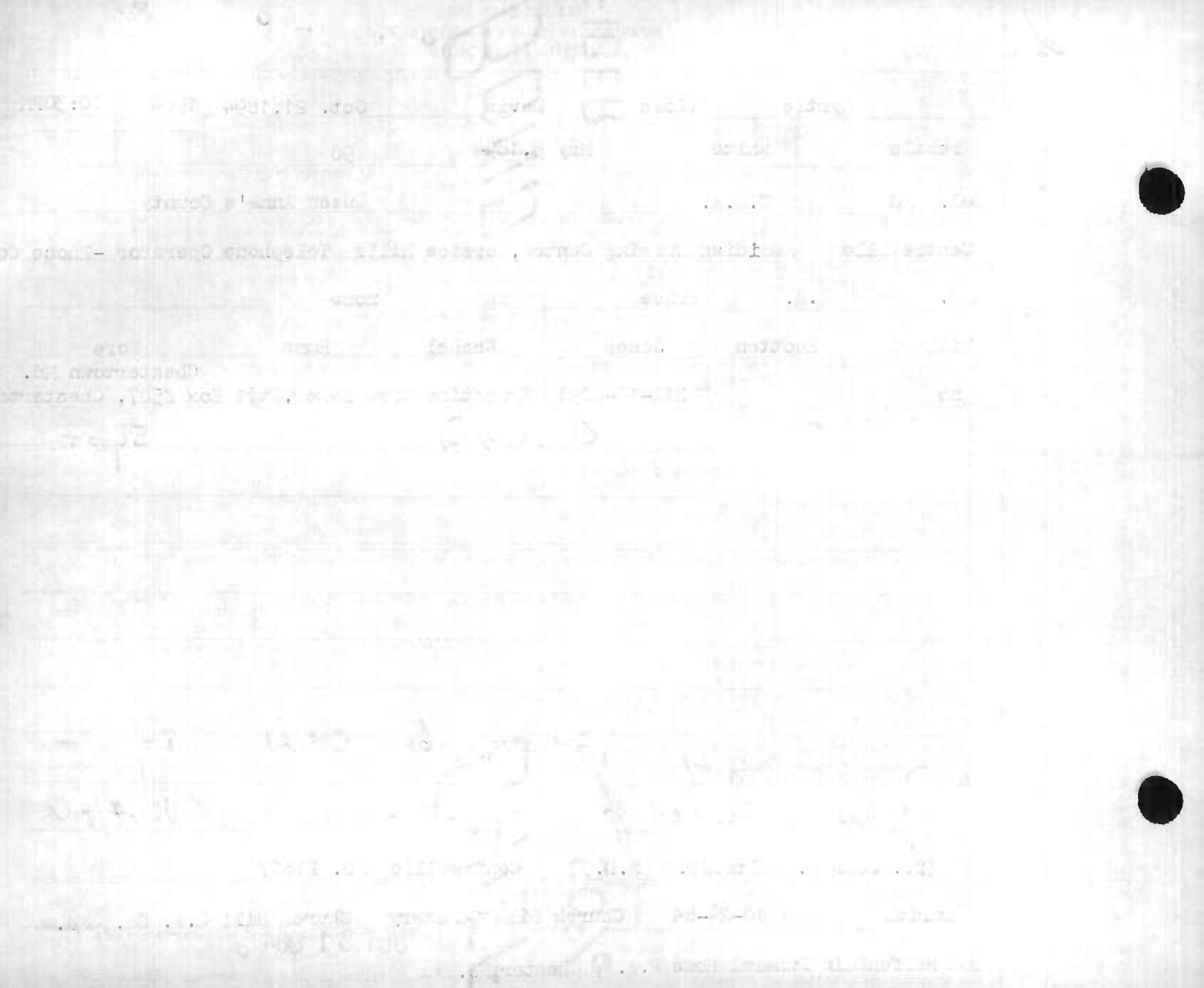
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Myrtle Viola Davis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 21, 1984</b>		2b. HOUR <b>10:30PM</b>	
3 SEX <b>Female</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 5, 1894</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Del.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Centreville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center, Corsica Hills</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Telephone Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-Phone Co</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Q.A.</b>	13c. CITY OR TOWN <b>Price</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>none 21656</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Willard Scotten Jones</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Emma More</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-10-0291</b>		17 INFORMANT ADDRESS <b>Chestertown Md. Ernestine Crew Baker, Rt#1 Box #507, Chestertown</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <b>ascvd</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Syst</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14, 1982</b> to <b>Oct. 21, 1984</b> , that (I) (we) lost the deceased alive on <b>Oct. 21, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John R. Smith, Jr.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/24/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. John R. Smith, Jr.</b>		M.D.		22e. ADDRESS <b>Centreville Md. 21617</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-24-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Church Hill Q.A. Co. Md.</b>
24 FUNERAL DIRECTOR NAME <b>Tom Helfenbein Funeral Home P.A., Chester Md.</b>				25a. DATE REC'D BY REGISTRY <b>OCT 31 1984</b>		25b. REGISTRAR'S SIGNATURE

BP





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 8 5 4 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Addison Frampton</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 6, 1984</b>				2b. HOUR M <b>M</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Corsica Hills Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Storekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Q.A.</b>		13c. CITY OR TOWN <b>Chester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 2 Box 681-C</b>		<b>21619</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles C. Frampton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Blunt</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-32-1018</b>		17. INFORMANT <b>Ruth M. Frampton</b>		ADDRESS <b>same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Q SEVA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 3, 1984</b> to <b>Oct 6, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 5, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>John R. Smith, Jr.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. R. Smith, Jr.</b>				22e. ADDRESS <b>Centreville, Md 21617</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/08/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensville Q.A. MD</b>					
24. FUNERAL DIRECTOR NAME <b>Tom Helfenbein Funeral Home, Chester, MD 21619</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodale</b>			

BP



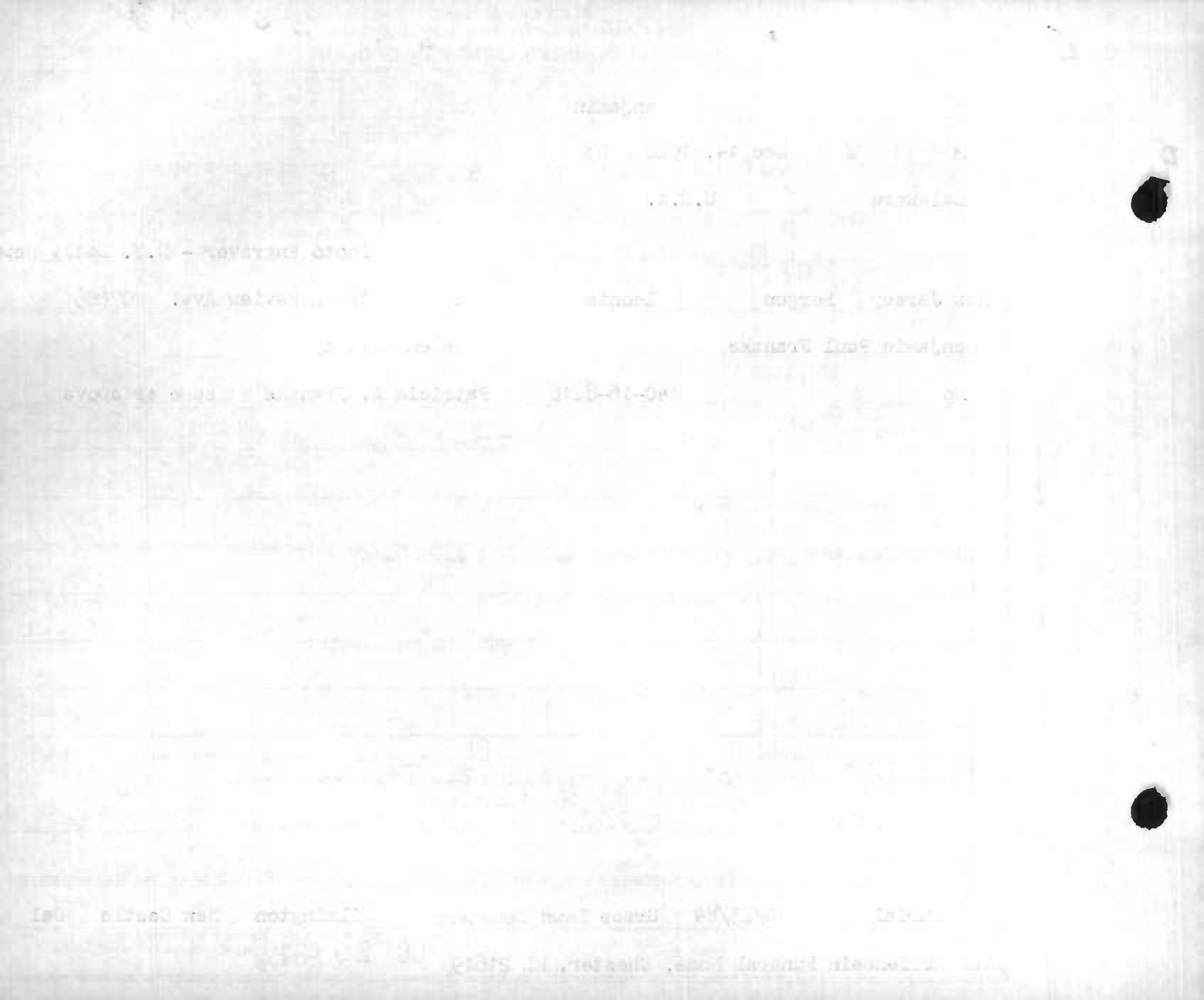
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28572	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Benjamin Franzke</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10-21 1984</b>		2b. HOUR M <b>1:00</b> P.M.		
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 14, 1920</b>		6 AGE (IN YEARS) LAST BIRTHDAY <b>63</b> YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-22 1984</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>				7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County, MD</b>	
10 CITY OR TOWN OF DEATH <b>Chester</b>				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box 560, Harbor Drive</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Photo Engraver - N.Y., Daily News</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>New Jersey</b>				13b CITY OR TOWN <b>Bergen</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>18B Lakeview Ave.</b>		13e <b>07605</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Paul Franzke</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Bordley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>140-16-8216</b>		17. INFORMANT ADDRESS <b>Patricia A. Franzke same as above</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE SIGNED <b>10-22-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>10/25/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>Grace Lawn Cemetary</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington New Castle Del</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>/Tom Helfenbein Funeral Home, Chester, MD 21619</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 29 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR OFFICE. IF YOU ARE A FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ALAN</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>10-14-84</b>			7b. HOUR <b>2AM</b>		
3 SEX <b>MALE</b>	4 RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-13-61</b>	6 AGE (IN YEARS) (LAST BIRTHDAY) <b>23</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-14-84</b>	7d. HOUR <b>2AM</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Queen Anne's County</b>		
10 CITY OR TOWN OF DEATH <b>Sudleesville</b>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 300 J. Benton Cr.Rd.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TILE SETTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TILE CO.</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>EDGEWATER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WALTER GAVRILENKOWSKY</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JUDITH EDGEWATER, MARYLAND BRADY</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>217-82-3395</b>			17 INFORMANT ADDRESS <b>KIM MARIE GAVRILENKOWSKY SAME AS</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head and face injuries</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____								19 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-36</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10-14-84</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2) <b>occupant of an auto/fixed object impact subj. was binned inside of car</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hgw.</b>		21f. LOCATION STREET CITY OR TOWN STATE <b>Rt.300 J. Benton Cr. Rd. Sudleesville, Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>10-14-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH CEMETERY WEST RIVER ANNE ARUNDEL</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>ROBERT E. EVANS</b>			ADDRESS <b>1212 WEST ST. ANNAPOLIS, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John S. [Signature]</i>

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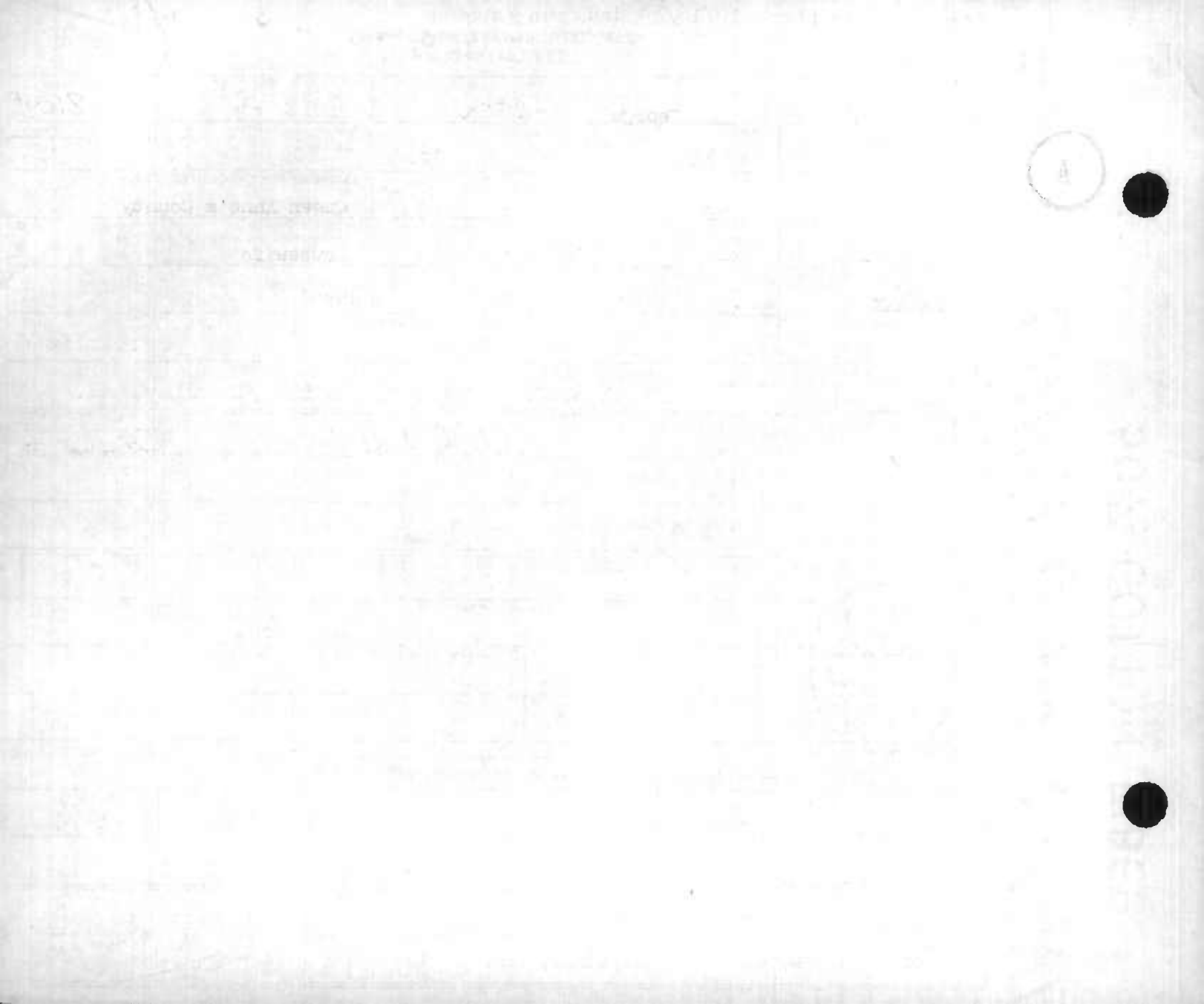


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13e per phone 10/16/84 dad										STATE OF MARYLAND									
1- FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- DECEASED NAME (TYPE OR PRINT)										REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) <b>HELEN George GREEN</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>9-28-84</b>									
3 SEX <b>F</b>										2b. HOUR <b>8:04 P.M.</b>									
4 RACE <b>white</b>										5. DATE OF BIRTH MONTH DAY YEAR <b>7 19 1893</b>									
6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b>										7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Queen Anne's</b>									
8. CITIZEN OF WHAT COUNTRY? <b>USA</b>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's County MD.</b>									
10. CITY OR TOWN OF DEATH <b>Centreville</b>										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian - Corsica Hills</b>									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>										12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD <b>Barclay</b>										13b. COUNTY <b>QA Co.</b>									
13c. CITY OR TOWN <b>Barclay</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Gibson</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Satterfield</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>										16b. SOCIAL SECURITY NO. <b>217-42-5981</b>									
17. INFORMANT ADDRESS <b>Clyde H. Cecil Barclay, Md.</b>										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASCU D</b>									
18. CAUSE OF DEATH (continued) (b) <b>5 yrs +</b>										18. CAUSE OF DEATH (continued) (c) <b>5 yrs +</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>1-17-79</b> , 19____, to <b>9-28-84</b> , 19____, that (I) (we) last saw the deceased alive on <b>9-27-84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <b>J.R. Smith, Jr.</b>									
22c. DATE SIGNED <b>10-1-84</b>										22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith, Jr. M.D.</b>									
22e. ADDRESS <b>Centreville, MD. 21617</b>										22f. DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>10-1-84</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Church Hill QA MD.</b>									
24. FUNERAL DIRECTOR <b>Tom Helfenbein</b>										25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1984</b>									
25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>										25c. ADDRESS <b>Chester, Md.</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/B3  
(VRA 15, 4)

1 - FOR STATE REGISTRAR

Edna H EATLOCK

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28545

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edna Rose Heacock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 30 84</b>			2b. HOUR <b>7:30 am</b>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 21, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. UNDER 23 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Stevensville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at her home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Zoology Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Univ. MD</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Q.A.</b>		13c. CITY OR TOWN <b>Stevensville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Bay City Box 16-6 21666</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Schiller</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nell Trotters</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-03-3048</b>		17. INFORMANT ADDRESS <b>Douglas Wallace, same asx above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung metotaris</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19____, to <u>9/30/84</u> , 19____, that (I) (we) last saw the deceased alive on <u>9/15/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Stanley Watkins</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/2/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Stanley Watkins</b>						22e. ADDRESS <b>Arundel General Hospital, Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/04/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>D.C. Arlington VA</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tom Helfenbein Funeral Home, Chester, MD 21619</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1984</b>		25b. REGISTRAR'S SIGNATURE <u>Dr. Stanley Watkins</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Mildred Elizabeth McFarland</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 3, 1984</b>			2b. HOUR <b>3:16 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 3, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's</b> MD			
10 CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Nursing Center/Corsica Hills</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Queen Anne's</b> 13c. CITY OR TOWN <b>Centreville</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>R.D. 2, Box 362, 21617</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Alexander Moore</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth French</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-26-9929</b>		17 INFORMANT <b>Sister</b> ADDRESS <b>R.D. 2, Box 362</b> <b>Mrs. Isabel McFarland, Centreville, Md. 21617</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AS C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years +</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 25, 1981</b> to <b>Oct. 3, 1984</b> , that (I) (we) last saw the deceased alive on <b>Oct. 3, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John R. Smith, Jr.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith, Jr., M.D.</b>				22e. ADDRESS <b>Centreville, Md. 21617</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 6, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centreville, Q.A.Co., Md.</b>			
24 FUNERAL DIRECTOR NAME <b>James H. Barton, Jr., Centreville, Md. 21617</b>				25. DATE RECEIVED BY REGISTRAR <b>OCT 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jelia Davidson-Randall</b>			



*[Faint, mostly illegible text and markings are visible across the page, including what appears to be a header section at the top and various lines of text below. The text is mirrored and difficult to decipher.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. FOR STATE REGISTRAR				28547			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Edward WALTERS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 7, 1984</b>		2b. HOUR P.M. <b>3:10 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 21, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>63 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne's</b> MD.	
10. CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R.D. 2, Box 27 residence,</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer(ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trailer</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Centreville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Linwood Casper Waters</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Cora Porter</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>220-12-2093</b>		17. INFORMANT ADDRESS <b>Brother P.O. Box 215 Clinton C. Waters, Centreville, Md. 21617</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Widespread metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE <b>Patrick A. Molony, M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/8/84</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patrick A. Molony, M.D.</b>				23b. ADDRESS <b>Chestertown, Md. 21620</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 9, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery Centreville, Q.A.Co., Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>James H. Barton, Jr., Centreville, Md. 21617</b>				25a. DATE RECD. BY REGISTRAR <b>OCT 11 1984</b>			
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 28548		
1. DECEASED NAME (TYPE OR PRINT) ELMER J. WOOLERY			2a. DATE OF DEATH MONTH DAY YEAR 10-5-84		2b. HOUR 54 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 3 95		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHESTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 321 Marling Farms		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Window dresser		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Queen Annes		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Woolery		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth (unknown)		13e. STREET ADDRESS / ZIP CODE Box 321 Marling Farms 21619			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW1		16b. SOCIAL SECURITY NO. 218-36-8041		17. INFORMANT Mrs. Alma Redsecker, Chester, Md.		17. ADDRESS 21619	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> LEISURE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>10-1-84</u> to <u>10-5-84</u> , that (1) (we) lost <u>10-5-84</u> the deceased alive on <u>10-5-84</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Ralph E. Libby</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-5-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph E. Libby, M.D.		22e. ADDRESS Grasonville Medical Center, Grasonville, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-8-84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.		ADDRESS		25. DATE RECEIVED BY REGISTRAR <u>10-8-84</u>			



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